

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

2624

1. PLACE OF DEATH

County Morgan
Township 40 N 24 E
City Glendale (No.)

Registration District No. 557
Primary Registration District No. 5175-0

File No. 1
Registered No. 597
St. Ward

2. FULL NAME

Sarah Ann Bowman

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert Bowman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
83 0 19 00

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Bedford Co.
(STATE OR COUNTRY)

10. NAME OF FATHER Benjamin Ripple

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bedford Co.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Margaret Flowers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bedford Co.
(STATE OR COUNTRY)

14. INFORMANT Mike Pyzka
(Address) 218 Rutger, St. Louis, Mo.

15. FILED Jan 22, 1929
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 19 29

17. I HEREBY CERTIFY That I attended deceased from Jan 14, 1929, to Jan 20, 1929.
That I last saw h. Jan 18, 1929, and that death occurred, on the date stated above, at 11:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) Lobar Pneumonia
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED NO
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

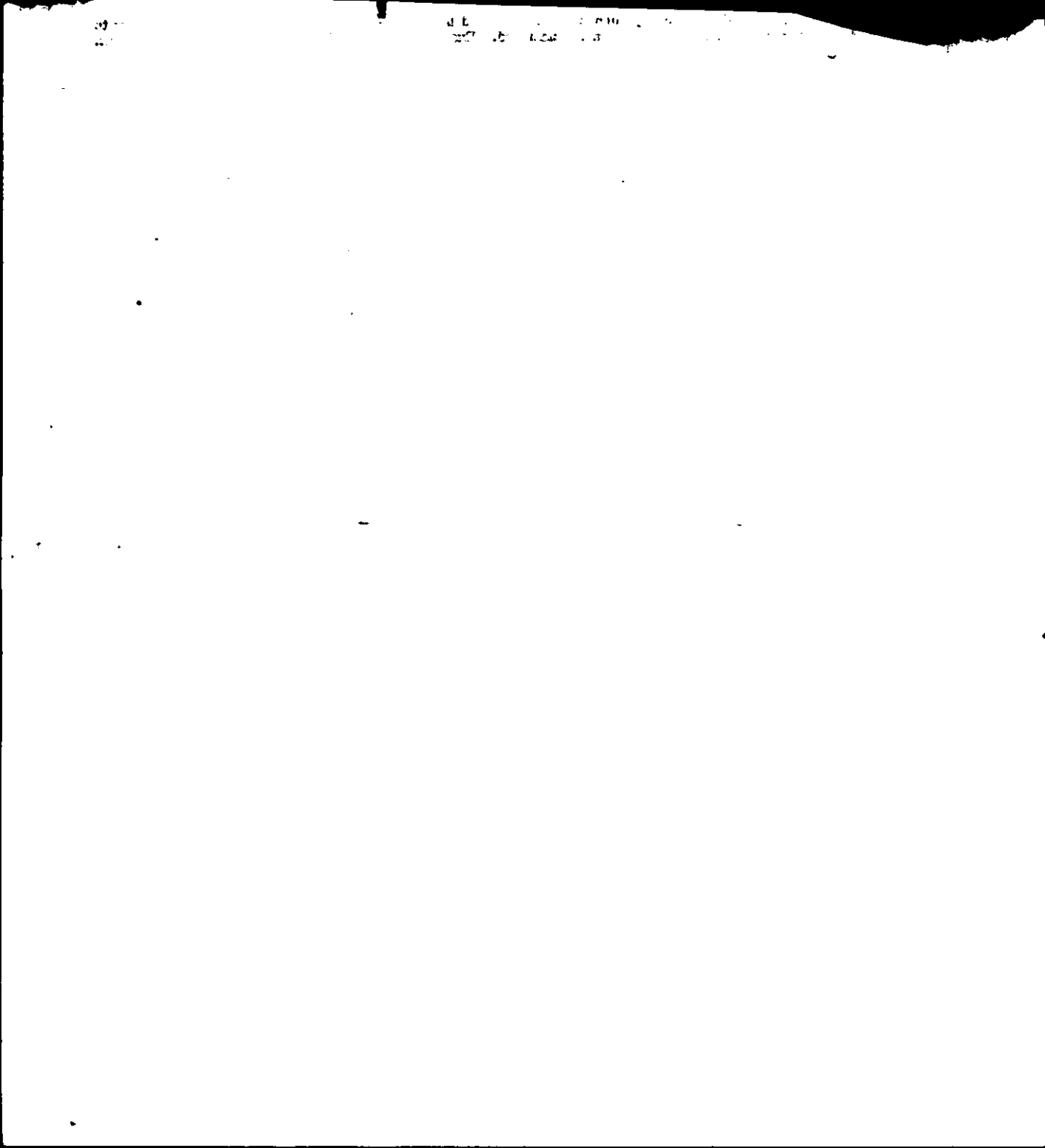
WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Symptom
(Signed) S. H. Melton, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Patrick's Cemetery DATE OF BURIAL 1/22 19 29

20. UNDERTAKER W. G. Phillips ADDRESS Olden



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Morgan Registration District No. 297 File No. _____
Township Orange Primary Registration District No. 2-795-A Registered No. 297
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/20/29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

14.

INFORMANT _____
(Address) _____

15.

FILED 1/23, 1929 W. L. Hatcher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 20 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY _____ (duration) _____ yrs. _____ mos. _____ ds.
(SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important

S-2624